DRN-5412122

The complaint

Ms H is unhappy with the service she received from Inter Partner Assistance SA when she claimed on her travel insurance policy.

Ms H is represented but I'll refer to all submissions as being made by her.

What happened

Ms H attended a private hospital as she was experiencing severe stomach pain. She contacted IPA for assistance. Ms H is unhappy with the service she received. She had suspected appendicitis and was awaiting surgery. She says delays by IPA in dealing with the claim placed her in a situation where her appendix burst and she developed peritonitis, which can be life threatening.

IPA then declined her claim on the policy, because they say she'd not accurately declared her medical history and, had she done so, she wouldn't have been offered the policy at all. Ms H complained but IPA maintained their decision to decline the claim. Ms H complained to the Financial Ombudsman Service.

Our investigator looked into what happened and didn't uphold Ms H's complaint. He thought IPA had reasonably declined the claim and that there hadn't been unreasonable delays when making a decision about cover. Ms H didn't agree and asked an ombudsman to review her complaint. In summary, she says she didn't make a claim connected to the conditions that weren't declared, there were some inaccuracies in her medical notes and that she didn't receive a good service from IPA.

In February 2025 I issued a provisional decision explaining that I was intending to uphold this complaint in part. I said:

> I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.
>
> In my view there are two key issues which are relevant to the outcome of this complaint. Firstly, whether IPA fairly declined the claim. Secondly, whether they provided her with good customer service when she contacted them for urgent medical assistance.
>
> **Was it fair and reasonable for IPA to decline the claim due to Ms H's medical history?**
>
> The relevant law in this case is 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 (a policy). 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.

IPA thinks Ms H failed to take reasonable care not to make a misrepresentation when she answered questions about her medical history during the application process. She was asked:

> '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?'

Ms H answered this question 'no'. However, I think IPA has reasonably concluded she ought to have answered this question as 'yes'. The policy was taken out in June 2023. I've reviewed Ms H's medical records, and the notes show that Ms H had active medical issues recorded. That included osteoporosis in May 2023 and fibrous dysplasia of her jaw in March 2023. Ms H had a bone scan on 29 March 2023 and blood tests at around the same time. Ms H had also used sertraline and been treated by her GP for a urinary tract infection during the relevant time period.

Ms H says that she was unaware of the osteoarthritis diagnosis and that her GP has recently confirmed it's presence but at such a low level no treatment was required. She says she discounted the blood tests because she'd been told they were normal. She also explained the Fibrous Dysplasia was a condition that had no impact on her day-to-day life. Finally she said that these issues had no bearing on the reasons for her claim.

I understand, and empathise, with Ms H's position. However, she was asked to declare any medical condition or psychological condition which had required prescribed medication or treatment including tests and investigations. Based on the evidence that's available to me Ms H was prescribed medication, underwent tests and had some investigations into her health. I appreciate that some of the conditions were relatively minor, and that the sertraline was prescribed on a short-term basis following some challenging life circumstances. I also understand that other conditions may not have impacted her daily life. But that's not what she was asked to declare during the application process.

IPA has demonstrated that if Ms H had answered 'yes' to that question she would not have been able to take out this policy. Instead, she'd have been directed to a different policy which covered consumers with a medical history. This means I'm satisfied Ms H's misrepresentation was a qualifying one. Although Ms H's appendicitis wasn't linked to these conditions, they were relevant to whether IPA would have offered her a policy and accept the risk of her making a claim. So, in the circumstances of this case, it's not unreasonable for IPA to decline the claim even though there's no connection between the conditions that were not disclosed and the reason for Ms H's claim. That's because if she'd disclosed the conditions IPA would not have accepted the risk of covering her and offered her this policy.

IPA has said Ms H's misrepresentation was reckless. I don't agree that Ms H's misrepresentation was reckless. I don't think she deliberately sought to deceive IPA about her medical history. I think it's more likely it was an oversight on her part. In reaching that conclusion I bear in mind that testimony that Ms H has given which I've found to be credible and persuasive.

As I'm satisfied Ms H's misrepresentation should be treated as 'careless' I've looked at the actions IPA can take in accordance with CIDRA. As IPA wouldn't have offered Ms H this policy, they are entitled to cancel the policy and refund the premiums to her.

Taking all of the above into account I think IPA has acted fairly and reasonably by declining the claim. But I don't think they fairly concluded, in the circumstances of this complaint, that the misrepresentation was deliberate or reckless. So I think IPA needs to refund the premium Ms H paid.

Did Ms H receive good customer service when she contacted IPA for assistance?

IPA has a responsibility to handle claims promptly and fairly. And, they shouldn't reject a claim unreasonably.

IPA cannot provide a copy of any of the relevant call recordings. So, where there's missing or incomplete information I've considered what's most likely to have happened. In reaching my conclusions I've taken account of the evidence which is available, including Ms H's testimony.

I'm not persuaded that Ms H did receive good customer service, or reasonable assistance, when she contacted IPA for emergency medical assistance. The NHS considers appendicitis as a condition which needs 'urgent treatment in hospital'. It says:

'If appendicitis is not treated quickly, your appendix can burst. If this happens your pain may suddenly get better for a short time….

If your symptoms mean it's very likely you have appendicitis, or if your appendix may have burst, doctors may recommend surgery instead of waiting for more tests…

If you need surgery, it will be done as soon as possible, but you may need to wait a few hours. The operation usually takes about an hour'.

The NHS also sets out the risks of a burst appendix which include peritonitis, sepsis, abscess, or a bowel blockage. It says such complications will need to be treated urgently with surgery and antibiotics.

When Ms H first contacted IPA, they were made aware that Ms H had suspected appendicitis, and the hospital was requesting confirmation of cover. IPA's notes say 'COP sent to the TH' so I think it's reasonable to conclude they were aware of Ms H's location and that she was at private hospital. During the third call to IPA the notes say Ms H called chasing the guarantee of payment so she could have her operation and that she seemed to be in 'so much pain'.

It wasn't until four hours after Ms H's first contact with IPA that the notes indicate that there was a discussion about Ms H having the option to go to a public hospital. By this point Ms H was on a drip and said she'd stay where she was. Ms H says that the

treating hospital refused to move her due to her condition and there's a contemporary note on IPA's file indicating that she made IPA aware of this. Ms H was told that the procedure might take a while but there's no indication that her claim was being treated with adequate urgency or that she was given a meaningful insight into timescales.

Ms H called six hours later, and the medical team still hadn't reviewed the medical information the hospital had sent. Ms H was described as 'crying and panicking'. At this point the claim seems to have been escalated.

IPA's notes say that they told Ms H they'd received the first medical report by the time they spoke to her at 0024 and that it had been stepped up to the medical team for review. According to the notes the medical team first reviewed the medical evidence at 1953 on 28 June 2023. This was nearly 24 hours after her initial call and nearly 19 hours after the report had been received. The medical team then said they needed a more detailed report although the notes don't clearly explain why more detail was needed. They also said they'd need her medical history for the last two years. In any event it wasn't until 1036 the following morning (the 29 June 2023) that Ms H was told they needed information from her GP to look into her medical history. This was when she called IPA for an update. It's unclear why this information wasn't requested at the outset given the urgency of the situation.

Ms H also said that one of the call handlers indicated she should indicate she didn't wish to see her medical records first to expedite the process with her GP. Ms H says she felt bullied into this by the call handler and her testimony on this point has been consistent and credible.

The GP initially didn't send the document IPA needed, just the password. By the 30 June 2023 at 1044 IPA's medical review indicates that they'd got a further medical report with more detail. IPA has not provided a copy of that report with the file and it's unclear when it was received by them. This was a surgical report and stated that Ms H had 'acute appendicitis with generalised peritonitis, with abscess'. The medical review concluded that this was an acute diagnosis not related to Ms H's medical history. Ms H was notified of the decline of the claim at 1313 on 30 June 2023 during a call with IPA.

Taking all of the above into account I'm not satisfied that IPA handled Ms H's claim promptly and fairly. IPA knew from the outset that Ms H had a condition which is time sensitive and, if left untreated, can lead to serious complications and which can be life threatening if left untreated.

I'm not persuaded Ms H's claim was treated with sufficient urgency. For example, there were unreasonable delays in reviewing the medical evidence. And, IPA could have been more proactive in obtaining Ms H's medical history at the outset as I think it's something that IPA were always most likely to need given the level of cover under the policy and the circumstances of the admission. This led to further delay. There was little proactivity on IPA's part and I think it would have been appropriate to treat Ms H's case with greater urgency. I also think they could have given her greater guidance when she first got in touch with them for assistance.

IPA were also aware from the outset that she was in a private hospital and yet she wasn't given guidance about moving to a public facility. Based on the evidence that's available to me her condition worsened during the period of time she was awaiting a decision on cover, to the extent that she could no longer move because she was so unwell.

Whilst this doesn't mean that IPA should cover Ms H's claim costs I've thought about what is fair and reasonable in the circumstances. I'm satisfied the unreasonable delays caused Ms H distress and inconvenience at a time when she was suffering from a lot of pain. There are multiple references to how much pain Ms H was in and how upset she was. I also think it's reasonable to conclude the suggestion that she could move to a public hospital came at a time when it was too late to do so, which limited her options significantly. She's therefore incurred private healthcare costs.

Ms H has also provided evidence which persuades me, on balance, that the lack of support she received has had a lasting impact on her physical and mental health. That included accessing mental health support for the trauma she experienced. Whilst I accept that getting ill abroad is, in itself traumatic, I don't think IPA's actions ensured Ms H had adequate support.

Given that IPA's actions, and inactions, have had a substantial impact on Ms H I think it's fair and reasonable that they pay her £2000 compensation for the impact of the distress and inconvenience caused.

IPA didn't respond to my provisional decision. Ms H made further representations in relation to the compensation awarded for distress and inconvenience. She highlighted the impact of IPA's poor customer service on her mental health which had caused her to seek trauma therapy. Furthermore, she highlighted how the insinuation of dishonesty had been particularly hurtful. She asked me to consider a compensation figure in the region of £3400 to £3500 to recognise her out of pocket expenses related to the entire claim.

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 considered Ms H's representations I'm satisfied that £2000 compensation is fair and reasonable in all the circumstances.

In my provisional decision I explained that I had considered that the lack of support Ms H received has had a lasting impact on her physical and mental health. That included accessing mental health support for the trauma she experienced. I also considered that Ms H had issues with more than one call handler throughout the lifetime of the claim. I accept that this caused her considerable distress at an already very difficult time. And, whilst the call recordings aren't available, I've accepted what Ms H has said about how the lack of support made her feel and the impact on her. I also took into account that the claim was declined on the basis that it was reckless rather than careless. So, these were all factors I had considered when deciding that £2000 compensation was fair and reasonable.

I appreciate that Ms H did incur a lot of out-of-pocket expenses as a result of the claim being declined. That's her financial loss in relation to the claim. And, for the reasons I explained in my provisional decision, I'm satisfied that the claim was, ultimately fairly declined. Therefore, I don't think it's fair and reasonable to say IPA should cover all the claims costs. My award of £2000 reflects Ms H's non-financial loss, which is the distress and inconvenience caused by the poor service she received from IPA.

Putting things right

IPA needs to put things right by paying Ms H £2000 for the distress and inconvenience caused by poor customer service. And they need to refund the premium she paid.

My final decision

I'm upholding Ms H's complaint and direct Inter Partner Assistance SA to put things right in the way I've outlined above.

Under the rules of the Financial Ombudsman Service, I'm required to ask Ms H to accept or reject my decision before 17 April 2025.

Anna Wilshaw
Ombudsman