DRN-5970354

The complaint

Mr M complains Inter Partner Assistance SA (IPA) has declined the claim he made under his travel insurance policy for medical treatment he received whilst abroad.

Mr M is being represented in this complaint by a family member who I'll refer to as Mrs M.

What happened

The circumstances of this complaint will be well known to both parties and so I've summarised events.

Mr M held a travel insurance policy provided by IPA. The policy was due to run from 16 September 2023 until 15 August 2024. Prior to Mr M's policy expiring he began suffering from stomach issues and so he saw a doctor and had blood tests.

Mr M was planning to extend his stay abroad and so Mrs M contacted IPA to ask about extending the policy. IPA said it would be unable to extend Mr M's policy as he was currently under investigation for a medical condition.

In September 2024 Mrs M called IPA to ask about the extension of the policy again as Mr M required some further medical treatment. IPA set up a medical assistance claim for Mr M and asked for further information about the treatment he was having carried out. On 25 September 2024 IPA told Mr M before it could make a coverage decision, it's medical team would need to see the results of the test Mr M had scheduled for 3 October 2024.

Mr M went ahead with the treatment and submitted a claim for the reimbursement of the medical expenses he had incurred. At the beginning of November 2024 IPA told Mrs M the medical expenses would be refunded but then told her it would need Mr M's past medical history before it could agree this. Following a further review IPA told Mrs M it would be declining the claim as the medical treatment had been received after Mr M's policy had expired. Mrs M was unhappy with the way the claim had been handled, and the decision IPA had made and so raised a complaint.

On 6 December 2024 IPA issued Mrs M with a final response to the complaint. It said it acknowledged there was a delay in making a coverage decision and it should have been more proactive in keeping her updated. It said it apologised she was told payment would be received and that this was later retracted. It said it wouldn't be overturning its decision to decline the claim as the policy had expired after the initial doctor's visit and before Mrs M had contacted it in September 2024. It said it would pay Mrs M £100 compensation as an apology. Mr M referred the complaint to this Service.

Our Investigator looked into things. She said she thought it was reasonable for IPA to decline Mr M's claim because the treatment received took place after the policy had expired, and it wouldn't be considered emergency treatment. She said she thought the £100 compensation IPA had paid was reasonable.

Mrs M didn't agree with our Investigator. She provided a detailed response but in summary

she said:

- She didn't think it was reasonable IPA didn't agree to extend the policy.
- In a call with IPA, it confirmed not renewing the policy was an error, expenses would be reimbursed and Mr M would be covered until treatment was complete.
- Had she been aware Mr M's claim wasn't covered she could have explored alternative options such as bringing Mr M home for treatment.
- The £100 compensation was never received.

I issued a provisional decision about this complaint and I said:

> *'I want to acknowledge I've summarised Mr M's complaint in less detail than it's been presented by Mrs M. I've not commented on every point she has raised. Instead, I've focussed on what I consider to be the key points I need to think about. I mean no discourtesy by this, but it simply reflects the informal nature of this Service. I assure Mr M and IPA I've read and considered everything that's been provided.*
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> *Mr M's policy schedule shows his policy expired on 15 August 2024. IPA has said it was unable to extend Mr M's policy as he was awaiting investigations into a medical condition. So, I've considered whether this was reasonable.*
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> *IPA has provided copies of the emails it sent to Mr M where it offers him the option of extending his policy if he contacts it. The emails explain there are some cases where it won't be able to offer an extension such as if Mr M has had a change in health. The terms of Mr M's policy are also clear it doesn't provide cover for any pre-existing medical conditions.*
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> *So, I'm persuaded IPA's decision not to extend Mr M's policy was in line with its standard processes, and Mr M has been treated the same as anyone else would have been in his position. Whether IPA chooses to extend an insurance policy is ultimately a business decision and not one I intend to interfere with. Therefore, I think IPA treated Mr M fairly when it didn't agree to extend his policy.*
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> *M had some treatment prior to his policy expiring, but the cost of this fell below his policy excess and so there was no settlement due to be paid to him. The rest of the treatment Mr M had carried out took place after the policy had expired and IPA has said this treatment isn't covered, so I've considered whether this is reasonable.*
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> *Strictly speaking, as Mr M's policy had expired at the point he had further treatment, there is no cover under his policy for this. But as Mr M's illness and treatment begun prior to the policy expiry, if Mr M was medically unable to return home prior to his policy expiring, I would expect IPA to consider medical costs incurred beyond the policy expiry date. However, I've not seen persuasive evidence Mr M was unable to return home due to his illness or that he was unfit to return home until he had received further treatment. So, as the treatment Mr M has claimed for took place after the policy expired, and I've not seen evidence he would have been unable to return home for this treatment, I don't think it was unreasonable for IPA to decline his claim.*
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> *Mrs M has said there had been promises and assurances from IPA that it would cover the treatment. And had it made her aware there was no cover, she would have explored alternative options, such as returning Mr M home for treatment. So, I've considered whether the way IPA handled Mr M's claim has led him to incur costs he*

otherwise wouldn't have done.

Mrs M called IPA in September 2024 and a medical assistance claim was opened. The handler who Mrs M spoke to said the policy would be extended until the treatment had finished or until its medical team deemed it medically necessary. IPA then sent Mr M an email asking him to provide information so it could make a decision on the coverage of his claim. So, whilst I think the handler could have been clearer around the claim process, I don't think they promised the treatment would be covered, and the subsequent email made it clear information was needed before cover could be confirmed.

Mr M provided this information and chased for a response over the coming days. On 25 September 2024, the day of Mr M's consultation, IPA spoke with Mrs M and followed this up with an email. In this email it said before it could make a decision on cover it would need to see the results of the tests Mr M had scheduled for 3 October 2024 so it could see if it was linked to any pre-existing medical condition. It said its medical team had authorised this treatment but it said at this time it was unable to assist financially.

Again, I think IPA could have been clearer in setting Mr M and Mrs M's expectations around the review of the claim. Whilst consideration of whether the treatment was related to a pre- existing condition was relevant, so was whether the treatment was considered an emergency or whether Mr M could reasonably return home for the treatment rather than having it carried out abroad.

However, I've taken into consideration that IPA hadn't confirmed Mr M's treatment would be covered prior to it being carried out. It had been clear on 25 September 2024 that it was unable to assist financially and hadn't made a decision on the claim. So, I think Mr M went ahead with the treatment on 25 September 2024 and 3 October 2024 knowing there was no guarantee this treatment would be covered.

Whilst I acknowledge Mrs M has said there were assurances from IPA it would cover the cost of the treatment, I'm satisfied IPA hadn't confirmed it would cover the cost of the treatment prior to Mr M having this carried out. So, I don't think IPA made an error which has led him to incur costs he otherwise wouldn't have done. Therefore, I don't require IPA to cover the cost of Mr M's treatment.

IPA has acknowledged it didn't handle Mr M's claim as well as it should have done. It has said there were unreasonable delays and it had told Mrs M it would be paying the medical expenses before retracting this. It said it paid Mrs M £100 compensation, although I acknowledge she has said this wasn't received.

I want to make clear that when making awards of compensation, this Service are only able to award compensation to eligible complainants. In this case, that would be anyone who was insured under the travel insurance policy. As it was only Mr M insured on the policy, I'm only able to make awards of compensation for distress and inconvenience caused to him specifically. And so, whilst I've no doubt the way IPA has handled Mr M's claim has caused Mrs M distress, I'm unable to take this into consideration when deciding fair compensation.

Given the nature of Mr M's claim, I think he would have always experienced some distress and inconvenience. However, I think the way IPA has handled his claim has caused him additional distress and unnecessary inconvenience which could have been avoided. Whilst I think Mr M would have always had the disappointment of his claim being declined, I think the time it took for IPA to reach a claim decision has

caused him unnecessary distress. The uncertainty about whether his claim was covered would have caused him distress, and whilst Mrs M has dealt with much of the claim on his behalf, I can see he sent emails chasing for a response. I've also taken into consideration that at this time Mr M was unwell, and in a foreign country away from his family.

IPA also told Mrs M the expenses would be paid before confirming it would need to see Mr M's medical history. This error was after the medical expenses had already been incurred, and was corrected later that day. But I acknowledge Mr M has likely suffered a loss of expectation due to Mrs M being told the expenses were being reimbursed.

Taking all of this into consideration I think £300 compensation is more reasonable to acknowledge the impact IPA's errors had on Mr M. I think this fairly takes into consideration Mr M's inconvenience was mitigated by having a representative dealing with much of the claim on his behalf, but that he has suffered unnecessary distress and inconvenience nonetheless.'

IPA accepted the provisional decision. Mrs M provided a detailed response but in summary she said.

- She received both verbal and written confirmation the medical expenses would be reimbursed before they were incurred.
- IPA's decision to decline the claim after treatment was completed and costs were incurred is wholly unreasonable.
- IPA didn't at any point indicate an issue in relation to the timing of the policy, only that the medical records were outstanding, which it failed to request in a timely manner.

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've reached the same outcome to the one I reached previously for much the same reasons as before.

Mrs M says she was provided with assurances and confirmation the medical expenses incurred would be reimbursed prior to the treatment being carried out. She's referred to promissory estoppal and said it's unreasonable for IPA to now decline the costs incurred.

I've not seen evidence IPA told Mrs M the treatment costs would be reimbursed prior to them being incurred. Whilst I acknowledge the call handler in September 2024 could have been clearer about the process, I don't think they guaranteed medical expenses would be reimbursed. And in any event, following this call an email was sent from IPA to Mr M asking him to provide information so a decision on coverage could be made. Additionally, the email sent on 25 September 2024, before Mr M had treatment, said a decision on Mr M's claim hadn't yet been made and it was unable to assist financially at that time. Therefore, I think Mr M and Mrs M would have been reasonably aware IPA hadn't agreed to reimburse medical expenses and the claim was being considered prior to the treatment costs being incurred.

I acknowledge in a telephone call in November 2024 IPA told Mrs M the medical expenses would be reimbursed. However, this was corrected the same day, and the costs for

treatment had already been incurred. So, I don't think this misinformation led to Mr M incurring medical expenses he otherwise wouldn't have done.

Whilst I acknowledge what Mrs M has said, I'm not persuaded IPA had promised or guaranteed it would reimburse Mr M's expenses before they were incurred. And whilst I acknowledge this will be disappointing for Mr M, I don't require IPA to reimburse these expenses.

I acknowledge IPA failed to request Mr M's medical history within a reasonable period of time, and as explained in the provisional decision, the claim wasn't handled as well as it should have been. So, I require IPA to pay Mr M a total of £300 compensation to acknowledge the distress and inconvenience it has caused him.

My final decision

For the reasons I've outlined above, I uphold Mr M's complaint about Inter Partner Assistance SA. I require it to pay Mr M a total of £300 compensation, minus any compensation it has already paid as part of this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr M to accept or reject my decision before 22 December 2025.

Andrew Clarke
Ombudsman